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West Melton Lodge

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 14 March 2017. The home was previously inspected in November 2016, and at the time was rated requires improvement with two breaches of regulations. Previously the service had been rated Inadequate in February 2016. We brought this inspection forward due to concerns we had about the service and to check if improvements had been made. You can read the report from our last inspections, by selecting the 'all reports' link for 'West Melton Lodge' on our website at www.cqc.org.uk'

West Melton Lodge is in West Melton village, which is between Rotherham and Barnsley. The home is registered to provide accommodation for 32 older people. Accommodation is on two floors and a passenger lift is provided. There are several lounges and dining areas throughout the home. The bedrooms vary in size and some have en-suite lavatories. The home has landscaped gardens and there is a car park to the front of the property.

There was not a registered manager for the service in post at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are "registered persons". Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager had left the same week as our inspection in November 2016; they were moved to another location owned by the provider. A manager who was previously registered at this location but left in 2016 was reappointed and commenced in November 2016. They had submitted an application to register with CQC.

The provider had systems in place to protect people from abuse and staff were aware of the procedures to follow. However, we identified these had not always been followed. People had not been protected and we made a safeguarding referrals to the local authority following our inspection.

People were not always protected against the risks associated with the unsafe use and management of medicines. Appropriate arrangements were in place for the recording, safe keeping and safe administration of medicines but these were not always followed.

People were assessed and risks to their safety and welfare had been identified. However, we found care was not always delivered in a way to manage these risks to ensure people's safety.

We found there was adequate staff on duty to be able to meet people's needs at the time of our inspection. However, from speaking with staff and people who used the service it was not clear if adequate staff were on duty in the evenings. We also identified from observations ineffective deployment and direction of staff meant people were not always appropriately supported.

We saw that appropriate pre-employment checks had been carried out to ensure staff were of good character and suitable to work with vulnerable adults.

We found the service was not always meeting the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). The staff we spoke with told us they had been requesting additional training as they were struggling to understand how this impacted on people they supported. People who used the service had been assessed to determine if a DoLS application was required. However, we found best interest decisions were not always made and where people had conditions as part of their DoLS authorisations had not always been met.

A well balanced diet that met people's nutritional needs was provided. However, we found people were not always supported appropriately to be able to eat and drink. We found best practice guidance was not always followed for people living with dementia in respect of aids for eating and adaptations to the environment.

Staff told us they had undertaken training to give them the skills and knowledge to carry out their roles. However, we found training was not up to date and staff did not always follow best practice.

The people we spoke to told us that the staff were caring, kind and considerate. However, this was not always reflected in what we observed. We found staff could be task orientated and care was not person centred.

We found people's care and support plans did not always reflect their needs. People were not involved in developing their plans and they did not always take into consideration their individual choices, preferences and interests.

People and their relatives we spoke with were aware of how to raise any concerns or complaints. Some complaints had been raised and it was not evident from records if appropriate action had been taken.

There were some processes in place to monitor the quality and safety of the service. However, we saw these were not effective and had not always been followed and had failed to identify the issues we found at the inspection.

We saw the process in place to ensure incidents were reported appropriately to the Care Quality Commission that are required by law had not been followed and incidents had not been notified.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

We found six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the registered provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Although people told us they felt 'safe', we found that people were not always safeguarded from the risk of harm. During the inspection we saw that safeguarding concerns had not been reported appropriately.

It was not evident if sufficient staff were on duty at peak times to meet people's needs and we observed staff were not always effectively deployed.

We found there were arrangements in place to ensure people received medicines as prescribed, however the systems were not followed.

Is the service effective?

Inadequate

The service was not effective.

People had their needs assessed, but their preferences and choices were not always documented and we observed they were not always met.

Staff did not understand how the Mental Capacity Act impacted on people they supported and did not always support people whilst considering their best interest. Conditions of Deprivation of Liberty Safeguards had not always been followed.

Staff had not always been appropriately supported or supervised to carry out their roles responsibilities.

Staff training was out of date and staff told us they had been asking for training to be able to meet people's needs.

Is the service caring?

Requires Improvement

The service was not always caring.

The people we spoke to told us that the staff were caring, kind and considerate and we saw some positive interactions between staff and people they supported. However, most care and

support we observed was task orientated.

Is the service responsive?

Inadequate

The service was not responsive.

People's care plans did not always detail their up to date needs and choices. The plans had been reviewed but any changes had not been incorporated into the main care plan to ensure people current needs were reflected.

People told us there was not much to do and lack of stimulation.

People felt that any concerns or complaints raised would be taken seriously by staff. However, we found lack of evidence to show people were listened to.

Is the service well-led?

Inadequate

The service was not well led.

The registered manager was moved to another provider location following our inspection in November 2016. A previous registered manager who left in early 2016 was reappointed and commenced in November 2016. We found the improvements the previous manager had commenced had not been taken forward and many areas had declined. Staff did not feel supported and lacked direction and leadership.

There were systems in place to monitor the quality of the service however; these had not identified issues that were picked up at inspection so were not effective.

West Melton Lodge

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.'

This inspection took place on 14 March 2017 and was unannounced. The inspection was carried out by two adult social care inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection, we reviewed the information we held about the service. This included correspondence we had received and notifications submitted by the service. A notification must be sent to the Care Quality Commission every time a significant incident has taken place, for example, where a person who uses the service experiences a serious injury.

We gathered information from the local authority commissioners and safeguarding team. This information was reviewed and used to assist with our inspection. We did not request a Provider Information Return (PIR) as the inspection was brought forward. The PIR asks the provider to give some key information about the service, what the service does well and improvements they plan to make."

As part of this inspection we spent some time with people who used the service talking with them and observing support. We looked around the service including bedrooms, bathrooms and communal areas. We looked at documents and records that related to people's care, including six people's support plans. We spoke with five people who used the service and two relatives.

During our inspection we spoke with the manager, one senior care worker, three care staff, one domestic and the cook. We also spoke with the operations manager and the provider at the end of the inspection. During the inspection we spoke with two visiting health care professionals to seek their views. We also looked at records relating to staff, medicines management and the management of the service.

Inadequate

Is the service safe?

Our findings

The people we spoke with told us that they felt safe. One person told us when asked if they felt safe, "Yeah I am, I always have [felt safe]." Another person told us that they felt safe because, "I always stay in my room." When we asked about the reasons for staying in their room, they told us that "I've always been a bit of a loner."

When discussing safety with a relative they told us, "Yes I would say it is safe, definitely." Another relative told us, "If there are any concerns, they [The staff] tell us straight away."

The provider had safeguarding policies and procedures in place to guide practice. Staff we spoke with seemed knowledgeable on procedures to follow including whistleblowing procedures. Staff could tell us how to recognise and respond to abuse. Some staff had received training in this subject, but the majority were out of date. We found only four out of 28 staff had up to date safeguarding training and four members of staff had no record of receiving any training.

What we found did not reflect what staff had told us; people were not always protected as they had not always identified abuse. For example, we identified that staff had recorded incidents in people's care files that were safeguarding incidents but they had not been reported appropriately. When we spoke with the manager they said they were not aware of the incidents. Correct procedures had not been followed to safeguard people. From evidence we found at the service we sent a safeguarding referral to the local authority following our inspection.

We looked at records in relation to accidents and incidents and found an analysis tool was in place to record actions and to monitor trends. However this was not always fully completed. We looked at care records and found some incidents which should have been recorded and analysed but they were not evident on the monitoring form. We also identified some incidents on the monitoring form that were not recorded in care files. It was not clear from evidence shown that people's incidents and accidents were managed appropriately. This meant any triggers or themes were not identified putting people were at risk of reoccurrence.

This was a breach of Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safeguarding service users from abuse and improper treatment.

One person we spoke with told us that there had not been any issues with staff responding to their needs in a timely manner. They told us, "The minute I press my buzzer they are there, two minutes, no later – same with everybody."

Another person told us that they had not had cause to press their buzzer during the night but said, "I pull it plenty during the day." They went on to tell us, "It's not many minutes until they [The staff] come." They added, "If they are busy they will say, can you wait a minute and tell me that they are busy then come back. I don't mind waiting." We saw this person had been waiting ten minutes on one occasion with the buzzer

ringing and no staff had been available to offer assistance. It was only answered when we asked staff why the buzzer was still ringing. The manager told us, "They don't know which buzzer to call and do it by accident." However when we went to see the person they did require assistance and were aware they had pressed the buzzer.

Staff we spoke with told us at times, particularly in the late afternoon early evening they struggled to meet people's needs with the staff on duty. We saw that after 1pm the care staff numbers reduced to three from four, the manager was still on duty in the week until 5pm but staff said after this and at weekends it was very busy from 5 – 8 pm. During this time people had their tea, were bathed, medication was administered and many people wanted to get ready for bed and be supported to get into bed. Staff told us seven people required two staff for all care needs and three people were cared for in bed; one of these people was receiving end of life care. There were also people who required bed rest during the day to alleviate pressure and prevent sores. Staff told us with only three staff on duty from about 4pm until 8pm it was extremely busy and on many occasions due to the layout of the home no staff were present in communal areas to support people and maintain safety.

We observed in the afternoon when people were being bathed and some going to bed for an hour, staff were attending to people in their bedrooms and not available to offer support to people in the lounge. It was not evident that adequate staff were on duty to meet people's needs. The manager had left early to attend an appointment but no extra care staff had been allocated on duty to ensure adequate staff were available to meet people's needs.

Through our observations we saw there were not always staff present in communal areas particularly during lunch. Staff were taking meals to people in their rooms and assisting people with meals in the lounge, therefore people who were sat in the dining room were without assistance. There was ineffective deployment of staff to meet people's needs.

This was a breach of Regulation 18 (1) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

We looked at two recruitment files of staff who had been employed recently and found the provider had a safe and effective system in place for employing new staff. The staff files we looked at contained pre-employment checks which were obtained prior to new staff commencing employment. These included two references, and a satisfactory Disclosure and Barring Service (DBS) check. The DBS checks help employers make safer recruitment decisions in preventing unsuitable people from working with vulnerable people. This helped to reduce the risk of the registered provider employing a person who may be a risk to vulnerable people.

We looked at the systems in place for managing medicines in the home. This included the storage, handling and stock of medicines and medication administration records (MARs).

A visitor told us that there had been an issue with their relative's medication on admission resulting in them having swollen ankles. They said the staff had taken over the administration of the medication and that the issue had quickly resolved and there had not been a recurrence.

We found a medication trolley was stored in the lounge although this had a thermometer in and it was checked, it was not a minimum/maximum thermometer so did not record the temperatures range over a 24 hour period. We also identified the medication refrigerator temperature was not being regularly monitored. It was therefore not possible to determine if medicines had been stored within the correct safe temperature

range.

We found staff who administered medicines did not always record the amount of medicines received or the amount carried forward from the previous month. This made it difficult to account for medicines. There were many missed signatures and hand written entries which were not signed. We also found many errors. For example we found one person's medication had 179 in stock at the start of the cycle, 57 had been signed as administered therefore 122 should remain and there was only 114 in stock. Another person had 69 in stock at the start of the cycle and 40 had been administered but only had 22 left in stock not 29 tablets. This meant staff could not always evidence medication was given as prescribed.

We found people were prescribed medication to be taken as and when required known as PRN (as required) medicine. For example, pain relief and to alleviate agitation. We found people did not always have PRN protocols in to provide guidance to staff when to give PRN medication and explain for example, how people presented when they were in pain and agitated but were not able to communicate this. Following our inspection in November 2016 the provider assured us these would be placed with people's MARs. Staff told us people who were prescribed these medications were not always able to tell staff when they were in pain or distressed due to their medical conditions. This meant that people who used the service could be in pain or distressed and not have medication administered as staff did not know what signs to determine when it was required.

We found on occasions people did not receive topical medication as prescribed. For example one person's cream stated apply as directed but there was no direction for staff to follow and the staff had recorded not required, however, there was no reason recorded why it was not required.

We checked controlled drugs (CDs), these are drugs covered by the misuse of drugs regulations. We identified one person's CD medication was incorrect; they had 28 received and 22 had been signed as administered so therefore six should be left and we found only five in stock. This meant one was unaccounted for. We asked the manager to investigate this.

The medication was administered by staff who had received training to administer medication. The manager told us all staff had received competency assessments, yet we found errors were still occurring so these were not effective. The medication audit completed on 25 January and 22 February 2017 were headed weekly audits but no other weeks had there been an audit completed. These audits did identify some of the issues we saw but did not address the majority of the errors identified therefore it was ineffective. We also found the person completing the audit did not know the policies, for example the auditor had written "meds pots hand washed and drained" and ticked as compliant, yet the policy stated medication pots should be washed in the dishwasher to adhere to infection control measures.

We saw people's risks had been assessed and documented in their care files. These had been reviewed. However, the care plan did not reflect any changes identified in the review to ensure people's needs were met and were protected from risk. For example one person had been assessed at risk of weight loss and we identified they had lost weight. However this was not addressed in the care plan or risk assessment to ensure care was planned and delivered to manage this risk.

We also noted a rope at the bottom of the two sets of stairs was still in place. This had been identified at our inspection in February 2016 and again in November 2016. We had asked the provider to identify an alternative arrangement as it posed a risk to people who used the stairs.

This was a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Safe care and treatment.

Inadequate

Is the service effective?

Our findings

At the last inspection we found a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Staffing. We found staff did not receive effective support, induction supervision, appraisal and training. The provider sent us an action plan telling us about the action they would take to address this. At this inspection we checked to see if improvements had been made.

We looked at records in relation to staff support and training. We found little or no training had been carried out in the four months since our last inspection. Although some staff told us they had completed training in dementia.

The manager showed us a schedule to complete staff supervision sessions. These were one to one meetings with their line manager. We saw these had only commenced in February 2017. The manager also told us yearly appraisals had not commenced and were out of date. We saw 18 staff had received supervision in February 2017; however, eight staff had still not received supervision. There was no clear evidence of regular supervision and no evidence was produced of appraisals having been carried out. This meant staff were not effectively supervised. Staff we spoke with told us they did not feel supported, one staff member said, "We are left to get on with it." Another said, "We could be more supported."

The manager showed us the training matrix which they told us was up to date. We saw from the records that only five staff out of 28 had completed DoLS training and only four staff out of 28 had up to date training in safeguarding of vulnerable adults however the provider's policy was to renew training yearly. We found much of the training was not updated in line with the provider's policies. Another example was moving and handling people training, only 11 staff had up to date training. We identified during the inspection that staff were using the incorrect sling for one person. Two people shared a room and both people required moving and handling. There were two slings in the room both size medium but different types. We saw staff used the incorrect sling on one person. When we asked the staff they though it was the correct sling but it was recorded in the care plan which one to use. We found the slings were unlabelled for the person they were to be used for. This put the person at risk not only of falling due to incorrect sling but a risk of cross infection. This evidenced training and supervision were not effective to ensure staff knew how to meet people's needs safely.

This was a continued breach of Regulation 18 (1) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Staffing.

The people we spoke with told us that their needs were being effectively met. One person told us "I like to see to myself, but if I don't feel well, I let them know and they help me." Another person told us, "The staff are great. They look after my every need. They are cheerful." When asked to expand on what needs the staff met for them they said, "They shave me, cut my hair, keep me clean, bath me."

People we spoke with told us staff generally respected their choices and decisions. From observation we saw people were given choices, although these were not always in consideration for people living with

dementia. We also found some care and support was task orientated and choices were limited.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. The authorisation procedures for restricting people's liberties in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act. We checked whether the service was working within the principles of the MCA.

We found the service was not always meeting the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). The staff we spoke with did not understand how this impacted on the people they supported and did not have an understanding and knowledge of the requirements. Some people who used the service had been assessed to determine if a DoLS application was required, however, it was not clear if all people had been assessed and if all relevant applications had been submitted.

Some people had conditions attached to their DoLS authorisations but we saw some of the conditions had not been met. Therefore people could have been deprived of their liberty in a manner which was unlawful. For example, one person's condition was to offer enough one to one time to take them out in the community although this had expired in January 2017 the new final approved DoLS had not been received but we saw no evidence over the last six months that any access to the community had been facilitated. Yet we saw this person walking around the home.

We looked at care records and found that mental capacity was not always clearly recorded. There was a 'Day to Day' mental capacity assessment in care files, this was a generic capacity assessment which did not give detail as to what choices and decisions the person was able to make. There were no best interest decisions documented where people lacked capacity to make a decision. These would ensure the decision made involved all relevant personnel and was made in the person's best interest. We saw consent was signed by family with no consideration to best interests.

This was a breach of Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Need for consent.

People we spoke with told us they liked the food. One person told us that they liked the food and that they had, "a bacon and egg buttie for breakfast".

We observed a member of the catering staff talking with one person and offer them a choice for lunch. The staff member engaged well with the person, gaining their attention, and it was clear from the person's response that the rapport between them was good and they were confident the catering staff member was aware of their likes and dislikes. However when we saw people living with dementia asked their meal choice it was not in a way they were able to make a decision. The choice was read from a list, there were no picture cards to help the person understand what each choice was to be able to make a decision. One person we observed could not make a decision so the member of staff said, "Oh you like [One of the choices] I will put you down for that."

We observed the lunch time meal; the food looked appetising and was well presented. However, we found the experience was poor for people who used the service. Staff were task orientated and focused on serving food to everyone, then leaving the dining room to give assistance to people in their rooms or in the lounge.

This left the people in the dining room without any assistance. We observed three people who were living with dementia struggling to eat their meal. One person was trying to pick the food up with their knife and by the time they got it to their mouth the food had fallen off. They persevered for 20 minutes then gave up. Staff took the plate away with the food uneaten. The person was not refusing the meal, instead they required assistance that was not offered. We noted the two other people who had struggled were also not offered any assistance. One other person had taken another person's drink and staff had not noticed, we had to inform the staff so the person who had their drink taken actually received a drink. We saw another person had pushed all their food off the plate trying to get it onto a fork; there was no plate guard to help the person.

A board was on the wall in the dining area which detailed the day's menu choices for all meals. This was above the window between the dining room and the lounge and behind a table so was not easily accessible for people to see. The writing was also very small so not easy for people to read. There were no picture menus to assist people with choices, pictures are particularly important for people living with dementia to understand the menu on offer.

We also saw people living with dementia were served food on plain white plates and one person had a patterned plate. Best practice guidance the 'EHE Environmental Assessment Tool' from Kings Fund 2014, suggests that if food and drinks are presented on coloured plates it appears more appealing to people living with dementia. At our previous inspection in November coloured plates had been used.

We saw health care professionals were accessed to seek advice, but we observed this was not always followed. For example, a healthcare professional had written in one person's care plan they had a moisture elision and required bed rest two hours in the morning and two hours in the afternoon in order for this to heal and not deteriorate into a pressure ulcer. We observed the person sat out of bed all afternoon. We spoke with healthcare professionals who told us the service was very good at contacting them for advice and felt in general this was followed.

This was a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person-centred cared treatment.

Requires Improvement

Is the service caring?

Our findings

The people we spoke with told us that the staff were caring, kind and considerate. Our observations evidenced staff were caring and kind. However, at times they were task orientated and did not deliver care in a person centred way. Staff told us they wanted to ensure people were comfortable, clean and that their dignity was maintained.

Visitors we spoke with were happy with the care provided. One relative told us that they take their relative's clothes home to be washed and can tell by the volume of washing that the staff team take care to ensure that their relative was changed frequently. Relatives also told us that staff respected people's wishes they explained how their relative liked to wear perfume and the perfume provided was being used.

We saw people were well presented in clean clothes and their hair well looked after, however, we did see two people's nails were a little dirty. By contrast, another person's nails were beautifully manicured and painted and they told us, "I choose what colour I want then they paint my nails for me."

People told us staff looked after them very well one person said, "They look after me very well – I have no complaints, I can have a laugh with them."

People told us they were treated with dignity and respect and one person said, "When the staff came to my room they knock, knock until I say come in."

We observed that the staff team explained to the residents what they were going to do, for example move them from one area of the home to another, and made sure that the resident with whom they were engaging had their attention

Visitors told us, "I can visit whenever I want and on my last visit there were five family members, but staff were still happy to provide drinks for us all."

We saw some positive interactions between people and staff. We saw staff engage in conversations talking with people about their families and hobbies, it was obvious from the conversation that the members of staff knew the people very well. However staff told us they did not have time to engage in conversation one staff member said, "We are lucky to get a break in the morning."

Some other interactions observed between staff and people who used the service were task focused. For example, we saw no support at meal times staff were just focused on serving all the meals and then clearing away. We saw meals placed in front of people with no explanation and staff rushing to get the meal finished and cleared away not making it an enjoyable experience for people. We also saw staff sat writing care notes in the lounge all together with no engagement with the people who used the service. The staff lacked direction and leadership to maintain a person centred care delivery and approach.

Inadequate

Is the service responsive?

Our findings

People we spoke with told us the staff were very good and met their needs. However, from observations and records it was not always evident that people's needs were met.

Relatives we spoke with told us that they had been involved in the care planning process in respect of their relative and had also contributed to some life story and memory work. We saw in some care plans that family had provided life story information, but in others there was no information for staff. This is particularly important when people are living with dementia so staff can understand what the person's likes, dislikes and hobbies are to be able to have meaningful conversations.

We looked at care plans and found they were not always a true reflection of people's current care needs. For example, one person's care plan stated they had poor mobility and were at risk of falls. The risk assessment was dated 22 September 2013 it had not been updated. Any falls should be documented on a body map. The person had fallen twice this year and there were no body maps despite both causing injury, as one resulted in a hospital admission. Another person's care plan stated the person could become very agitated in the evenings and for staff to manage this, however, the care plan did not give details of how to redirect, distract or manage the behaviour. The review showed the person had not presented with any behaviours that may challenge, therefore the care plan did not reflect their current needs. Another person's nutritional care plan stated they had a good appetite and staff just needed to prompt with food. We saw this person had lost considerable weight yet the care plan had not been updated.

We saw although people's care needs had been identified, the care delivery recorded to meet people's needs did not give sufficient or up to date detail to show how the care should be delivered to be able to respect their preferences and choices. Therefore this did not ensure staff were responsive to people's needs.

The service did not employ a dedicated activity co-ordinator. We identified lack of activities at our last inspection in November 2016. The provider told us they would allocate additional hours to care staff to be able to deliver activities. On the day of our inspection we observed a group of people playing a game of bingo which they had chosen as their activity for the morning. We also observed preparations being made for the regular visit of the hairdresser which people were looking forward to. There was also a church service in the afternoon, which some people participated in. However, we found most people did not engage in meaningful social stimulation or activity.

We found from looking at records that very few people were involved in any meaningful activity. People who were cared for in bed did not receive any social stimulation and could be isolated. Activity records we looked at recorded mostly watching television or listening to music. One person's record from 1 January 2017 recorded 37 entries, 'watching TV.' 10 entries stated, 'in his room.' three times talking to his wife, once playing bingo and three occasions washing pots in the kitchen. This person's care plan recorded they liked playing cards and dominoes, yet there was no record of this activity. There was no evidence meaningful activities regularly took place that could enhance and improve people's well-being. Research carried out by Bradford Institute for Health Research and Leeds University (research in enhancing physical activity in care

homes), has evidenced that activities benefit people living with dementia, it brings social interactions, positive sense of well-being and feeling valued by introducing meaningful activities that achieve a goal.

This was a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person-centred care.

People we spoke with generally told us that they knew how to raise an issue of concern. Relatives we spoke with told us that they had completed a satisfaction survey during the time of the previous manager but had not completed since the current manager had been in post. However, they had not seen any feedback from that survey.

The provider had a complaints procedure in place and was displayed in the reception area of the home. We spoke with the manager about complaints and were shown a log which contained very little information. It did not show the complainant was listened to or the outcome. For example one complaint received was from a relative the only action stated, "Will tell staff to do it more often." This did not evidence the complaint was resolved satisfactorily. Although people and their relatives we spoke with did not raise any issues or concerns during our inspection.

Inadequate

Is the service well-led?

Our findings

At the last inspection we found a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good governance. We found that although the provider had implemented systems to monitor the quality of the service following our inspection in February 2016, when the service was rated inadequate these had not continued. At our inspection in November 2016 these had not been fully embedded into practice, so could not determine if they were effective and if they would be sustained. The provider sent us an action plan telling us about the action they would take to reach compliance. At this inspection we checked to see if further improvements had been made.

Since our inspection in November 2016 the registered manger was moved to another provider location. The present manager commenced in November 2016. At this inspection we identified that the quality monitoring systems had not improved or been embedded into practice and were not effective.

We looked at records of audits completed and records we saw were either out of date or had not identified the issues we found during the inspection. For example, the last care plan audit was dated 31 May 2016, there was not one completed since then. The medication audit and the weekly walk around audit had not identified areas for improvement. We also saw the weekly audit was only completed on 7 November 21016, 14 November 2016 and 21 February 2017. There were no other records of this audit being completed.

The provider audit we were shown was dated February 2017 we saw two care plans had been checked and outcome was, they were person centred, reviewed and up to date. One of the care plans looked at was a person we had seen and the care plan was not up to date and did not reflect their current care needs. The provider audit also identified that residents meetings should be four times a year yet there had not been one since 11 May 2016.

We also identified that the provider had not met the compliance dates on the action plan they submitted to us following our inspection in November 2016. For example, the environmental improvements were still not completed. The mechanical sluice had been installed bu the room had not been decorated, no shelving had been installed and all the commode pots and urine bottles were on the floor. The linen store had also not been reorganised to ensure the area was clutter free and could be adequately cleaned.

We saw the provider had a record in place to record incidents, accidents and safeguarding concerns. We found these had not been recorded properly. We identified incidents in care files that had not been recorded on an incident form so were not included in any audit. This meant triggers and themes could not be identified to manage and reduce incidents. The audits were also recorded on two different formats and one did not even record the time of the incident so was not effective in analysing if there was a higher number of incidents at any particular time of day.

Relatives we spoke with told us that they had in the past completed surveys with regard to the service. One person told us that they were aware who the manager was, however, another person said, "I have no idea

who the manager is."

A relative told us that they were kept well informed of everything that was happening with regard to their relative. However, we saw no recent questionnaires had been sent to obtain people's views. There had been no recent meeting held to gain feedback and ensure people were listened to.

This was a continued breach of Regulation 17of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

The provider and manager were aware of their responsibility to inform the CQC about notifiable incidents and circumstances in line with the Health and Social Care Act 2008. However, we saw that we had not been notified about incidents that had occurred at the service. We identified three that had not been notified and the provider's audit had identified an incident that should have been notified and an action was for the manager to inform safeguarding, we have also not received this notification. We also found an incident in November 2016 we had been notified of this by the local authority but had not been notified to us by the service.

This was a breach of The Care Quality Commission (Registration) Regulations 2009. Regulation 18: Notification of other incidents.